

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b 2 1/2 hrs. 20 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.				d. STREET ADDRESS Barclay			
3. NAME OF DECEASED (Type or print) First Emma Middle Blanche Last Beatty				4. DATE OF DEATH Month Oct Day 3 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January, 30, 1886		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Taylor				14. MOTHER'S MAIDEN NAME Anna Skinner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Josephine B. Pennington, Barclay, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, left middle cerebral artery DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 3 days > 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease & congestive failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/2 19 61 to 10/3 19 61 , that (I) (we) last saw the deceased alive on 10/3 19 61 , and that death occurred at 2:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE Robert W. Trever				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		10/22b. DATE SIGNED 10/4/61	
22c. PHYSICIAN'S NAME (Type) Robert W. Trever				22d. ADDRESS M.D. Easton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 7, 1961		23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery		23d. LOCATION (City, town, or county) (State) Sudlersville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Bellows Millington Md.				25a. REC'D BY REGISTRAR DATE OCT 9 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Huns	

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From 2/1/17 to 2/28/17
Total amount paid
\$ 100.00

For 1917, the amount paid
\$ 100.00

For 1918, the amount paid
\$ 100.00

For 1919, the amount paid
\$ 100.00

For 1920, the amount paid
\$ 100.00

For 1921, the amount paid
\$ 100.00

For 1922, the amount paid
\$ 100.00

For 1923, the amount paid
\$ 100.00

For 1924, the amount paid
\$ 100.00

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11862

1. PLACE OF DEATH a. COUNTY TA/bot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TA/bot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 130 Port	
3. NAME OF DECEASED (Type or print) First George Middle Blackwell Last Blackwell		4. DATE OF DEATH Month Oct. Day 12 Year 1961	
5. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1902
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Blackwell		14. MOTHER'S MAIDEN NAME Katie Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 149-05-1191	
17. INFORMANT Annie Jenkins Address Easton md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Wine-O		INTERVAL BETWEEN ONSET AND DEATH Immediate	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from P.M. 19____, to 19____, that (I) (we) last saw the deceased alive on 19____, and that death occurred at ____ M., from the causes and on the date stated above.			
22a. SIGNATURE L. M. M. M.		22b. DATE SIGNED 10-13-61	
22c. PHYSICIAN'S NAME (Type) WELTV		22d. ADDRESS Easton md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-16-61	
23c. NAME OF CEMETERY OR CREMATORY Richards Cem		23d. LOCATION (City, town, or county) (State) Easton md.	
24. FUNERAL DIRECTOR'S SIGNATURE James Blackwell ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR DATE OCT 16 '61	
		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>5 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Breeze</u>		4. DATE OF DEATH Month Day Year <u>Oct 17 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 4 1904</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plummer</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Breeze</u>		14. MOTHER'S MAIDEN NAME <u>EMMA Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-16-556</u>	
17. INFORMANT <u>Elizabeth Breeze-Easton, md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive HSCVD.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5 PM 10/17 1961</u> to <u>9 PM 10/17 1961</u> , that (I) (we) last saw the deceased alive on <u>10/17 1961</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>L. J. Eglunder</u>		22b. DATE SIGNED <u>10/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. J. Eglunder</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Oct. 21, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Rashall Easton md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 24 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>			

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EXHIBIT OF DATA

State of New York
County of Albany
City of Albany
In and for the County of Albany
City of Albany
I, the undersigned, Clerk of the Court,
do hereby certify that the within
is a true and correct copy of the
original as the same appears on the
records of the Court.

Attest:
Clerk of the Court
Albany, N.Y.
1887

TO HO ~~ALL~~ OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11864

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XOXford d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Perry First Alexander Middle Brooks Last 4. DATE OF DEATH OCT. 27 Month 1961 Day Year		5. SEX MALE 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH MARCH 10, 1856 9. AGE (In years last birthday) 105 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND 11. BIRTHPLACE (State or foreign country) U. S. A. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Perry 14. MOTHER'S MAIDEN NAME Georgeanna Fields 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Anna M. Brooks - Oxford, Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO eps. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from June 1960 to 10-27-61 that (I) (was) last saw the deceased alive on 10-27-1961 and that death occurred at 7:30 A. from the causes and on the date stated above. 22a. SIGNATURE Donald F. Bartley M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) DONALD F. BARTLEY, M.D. 22d. ADDRESS EASTON, MD. 22b. DATE SIGNED 10-30-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 10-30-61 23c. NAME OF CEMETERY OR CREMATORY Oxford Cem. 23d. LOCATION (City, town, or county) (State) Oxford, Md.		24. FUNERAL DIRECTOR'S SIGNATURE James P. Hill - Easton, Md. ADDRESS EASTON, MD. 25a. REC'D BY REGISTRAR DATE NOV 6 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11881
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>TALbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MEMORIAL Hospital</i>		d. STREET ADDRESS <i>172-2</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Joseph William Collier</i>		4. DATE OF DEATH Month Day Year <i>10 18 1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 12 - 1881 - 76</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cystern & fishing</i>	
11. BIRTHPLACE (State or foreign country) <i>Seasowille</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Thomas Collier</i>		14. MOTHER'S MAIDEN NAME <i>Annie Collier</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-01-5669</i>	
17. INFORMANT <i>Antonia Louise Collier</i>		Address <i>Seasowille, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart disease</i> DUE TO (b) <i>and</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Strangulated umbilical hernia</i> DUE TO (c) <i>8 days</i> INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Interventricular heart disease Pulmonary edema</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10-10</i> <i>1961</i> , to <i>10-18</i> <i>1961</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>10-18</i> <i>1961</i> and that death occurred at <i>4:23</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Trever</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>10/23/61</i> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>		22d. ADDRESS <i>M.D. Easton, Maryland</i> <i>10/23/61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct 21 - 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Christiefield</i>		23d. LOCATION (City, town, or county) (State) <i>Centerville Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Butler Jr. & Butler Bros. Centerville, Md.</i>		25a. REC'D BY REGISTRAR <i>OCT 26 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

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TO D. COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with Form PM-3, Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

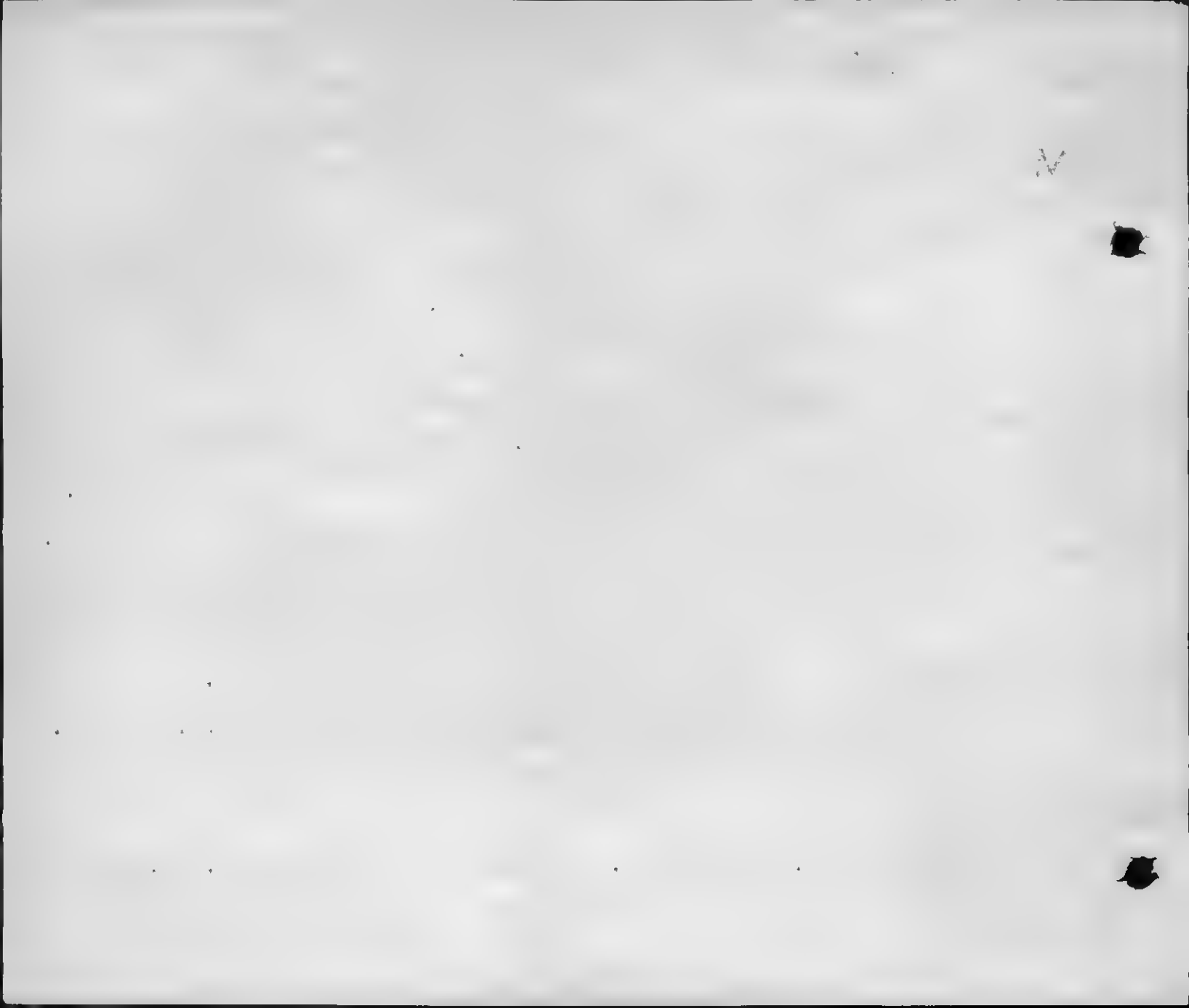
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11867

1. PLACE OF DEATH COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived, if Institution Residence before admission) a. STATE Maryland b. COUNTY J.A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester Kent Narrows d. STREET ADDRESS Quail Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b DOA		Month Oct. Day 29 Year 19 61	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital, Easton					
3. NAME OF DECEASED (Type or print) Andrew		First A. Middle M. Last Cottman		4. DATE OF DEATH Oct. 29 19 61	
5. SEX M.		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 14, 1904		9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months 5 Days 17	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Cottman	
14. MOTHER'S MAIDEN NAME Sara Robinson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Estelle Cottman		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Left Hemothorax Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. multiple stab wounds of left chest DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) none		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 hr	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) stabbed during a fight in a beer hall.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year 11:10 a.m. 10 29 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) tavern	
20f. (City or town) Chester		20g. (County) J.A.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE C. R. Layton		M.D. C. R. Layton, M.D.		DATE SIGNED Oct. 31, 1961	
EXAMINER'S NAME (Type) C. R. Layton, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 5, 1961	
22c. NAME OF CEMETERY OR CREMATORY Lawson Cemetery		22d. LOCATION (City, town, or country) Crisfield		22e. (State) Md.	
23. FUNERAL DIRECTOR Anthony E. Ward		24a. REC'D BY REGISTRAR NOV 2 '61		24b. REGISTRAR'S SIGNATURE Anthony E. Ward	



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the Medical Director. Pages 1, 2, and 3 to 10 should be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18 Form 301 11-2-61

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11883 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11868

1. PLACE OF DEATH
a. COUNTY Talbot **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton **10da**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp tal, give street address) Memorial Hospital
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton
d. STREET ADDRESS 1 Rt. 1-Box 244
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) Memorial Hospital First Middle Last
Preston Cornelius Dill
4. DATE OF DEATH 10 30 1961
5. SEX MALE 6. COLOR OR RACE Negro 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 6-26-12 9. AGE (In years less birthday) 49 yrs Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 10b. KIND OF BUSINESS OR INDUSTRY CRANE OPERATOR 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Emory Dill 14. MOTHER'S MAIDEN NAME Henrietta Dill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, and, or, unknown) yes (If yes give year or dates of service) WWII 219-07-3368 16. SOCIAL SECURITY NO. 219-07-3368 17. INFORMANT Buelah Dill - Easton, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Marked generalized and coronary atherosclerosis
420.1 DUE TO with marked coronary narrowing
Conditions, if any, which gave rise to immediate cause (b) with marked coronary narrowing
(c) with marked coronary narrowing
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) with marked coronary narrowing
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 11-2-61 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unionville Cem. 20f. (City or town) Unionville, Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 11-1-61
ACTUAL SIGNATURE Louis P. Welty M.D. EXAMINER'S NAME (Type) WELTY
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL 22b. DATE THEREOF 11-2-61 22c. NAME OF CEMETERY OR CREMATORY Unionville Cem. 22d. LOCATION (City, town, or country) Unionville, Md. (State)
23. FUNERAL DIRECTOR Garwood B. Dashiell ADDRESS 11-2-61 24a. RECEIVED BY REGISTRAR NOV 3 1961 24b. REGISTRAR'S SIGNATURE Arthur S. France
DATE



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11884

11862

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Offord</u> c. LENGTH OF STAY IN 1b <u>Entire Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived, if institutional, give date before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Offord</u> d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>L. Clarence Hobson</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 8, 1879</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John M. Hobson</u> 14. MOTHER'S MAIDEN NAME <u>Mary S. Hobson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>214-34-9134</u> 17. INFORMANT <u>Walter Hobson</u> Address <u>St. Michaels Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <u>NO</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 30, 1949</u> to <u>Oct. 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 14, 1961</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>S. Krech, Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>S. Krech, Jr.</u> 22b. DATE SIGNED <u>10/22/61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>EASTON, Maryland</u> 23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Oct. 24, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Offord Cemetery</u> 23d. LOCATION (City, town or county) <u>Offord Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. Newnam, Son</u> ADDRESS <u>Easton Md.</u> 25a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u> 25b. REGISTRAR'S SIGNATURE _____ DATE <u>OCT 26 '61</u>	

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>	
c. LENGTH OF STAY, IN 1b <u>13 days</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hester</u> Middle <u>Gleaves</u> Last <u>Gleaves</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Steven Cain</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-28-2953</u>	
17. INFORMANT <u>Charles Gleaves Greensboro, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>Unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-12</u> , 19 <u>61</u> , to <u>10-25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-24</u> , 19 <u>61</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-28-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Newtown</u>		23d. LOCATION (City, town, or county) (State) <u>Cardova, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Boulaia</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 30 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Wishing L. Harris</u>			



may be signed by the attending physician and completely filled by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) MARY Francis GRACE		4. DATE OF DEATH OCT. 13, 1961	
5. SEX Female	6. COLOR OR RACE Col	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 4, 1886
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR: Months 7 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Warner		14. MOTHER'S MAIDEN NAME Elizabeth Warner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220-05-1292	
17. INFORMANT Mrs. Sara Cooper - Sherwood, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary heart failure DUE TO (b) Hypertension, cerebral hemorrhage DUE TO (c) Hypertension CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/8 to 10/13, 1961 , that (I) (we) last saw the deceased alive on 10/13, 1961 , and that death occurred at 4:30 P. M. from the causes and on the date stated above			
22a. SIGNATURE J. M. REFSEGER		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) TILGHMAN M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-21-61	
23c. NAME OF CEMETERY OR CREMATORY Sherwood Cem.		23d. LOCATION (City, town, or county) (State) Sherwood, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James D. Doherty, Easton, Md.		25a. REC'D BY REGISTRAR DATE OCT 25 '61	
		25b. REGISTRAR'S SIGNATURE William S. Harris	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11872

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Maple Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>ANNA</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 - 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willis Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Betty Walls - Church Hill Ind.</u>		Address <u>Church Hill Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR OCCLUSION</u> 332X DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>MORBUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE IN CONGESTIVE FAILURE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/19/1961</u> to <u>10/19/1961</u> that (I) (we) last saw the deceased alive on <u>10/19/1961</u> and that death occurred at <u>1:30</u> M., from the causes and on the date stated above.		22a. SIGNATURE <u>S. Krech, Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/20/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. Krech, Jr.</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/22/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridgely</u>	23d. LOCATION (City, town, or county) (State) <u>Ridgely Ind.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Sam</u> ADDRESS <u>Church Hill Md.</u>		25a. REC'D BY REGISTRAR <u>DET 24 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Wm. S. Travis</u>	

(M)

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may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11873

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lida Middle May Last Griffin				4. DATE OF DEATH Month October Day 25 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1891	
9. AGE (In years last birthday) yrs 70		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		IF UNDER 24 HRS Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levin Spedden Seymour				14. MOTHER'S MAIDEN NAME Matilda Ann Burrridge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT R. Lee Griffin, S. Aurora St., Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO (b) Following acute Cold + Debility DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 Week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 12th 1961 to Oct 25 1961 that (I) (we) last saw the deceased alive on Oct 24th 1961 and that death occurred at 5 AM , from the causes and on the date stated above							
22a. SIGNATURE William S. Seymour M.D.				22b. ADDRESS Trappe, Maryland			
22c. PHYSICIAN'S NAME (Type) William S. Seymour, M.D.				22d. ADDRESS Trappe, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/61		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City, town, or county) (State) Easton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll				25a. REC'D BY REGISTRAR Easton, Md.		25b. REGISTRAR'S SIGNATURE W. L. S. F. F.	



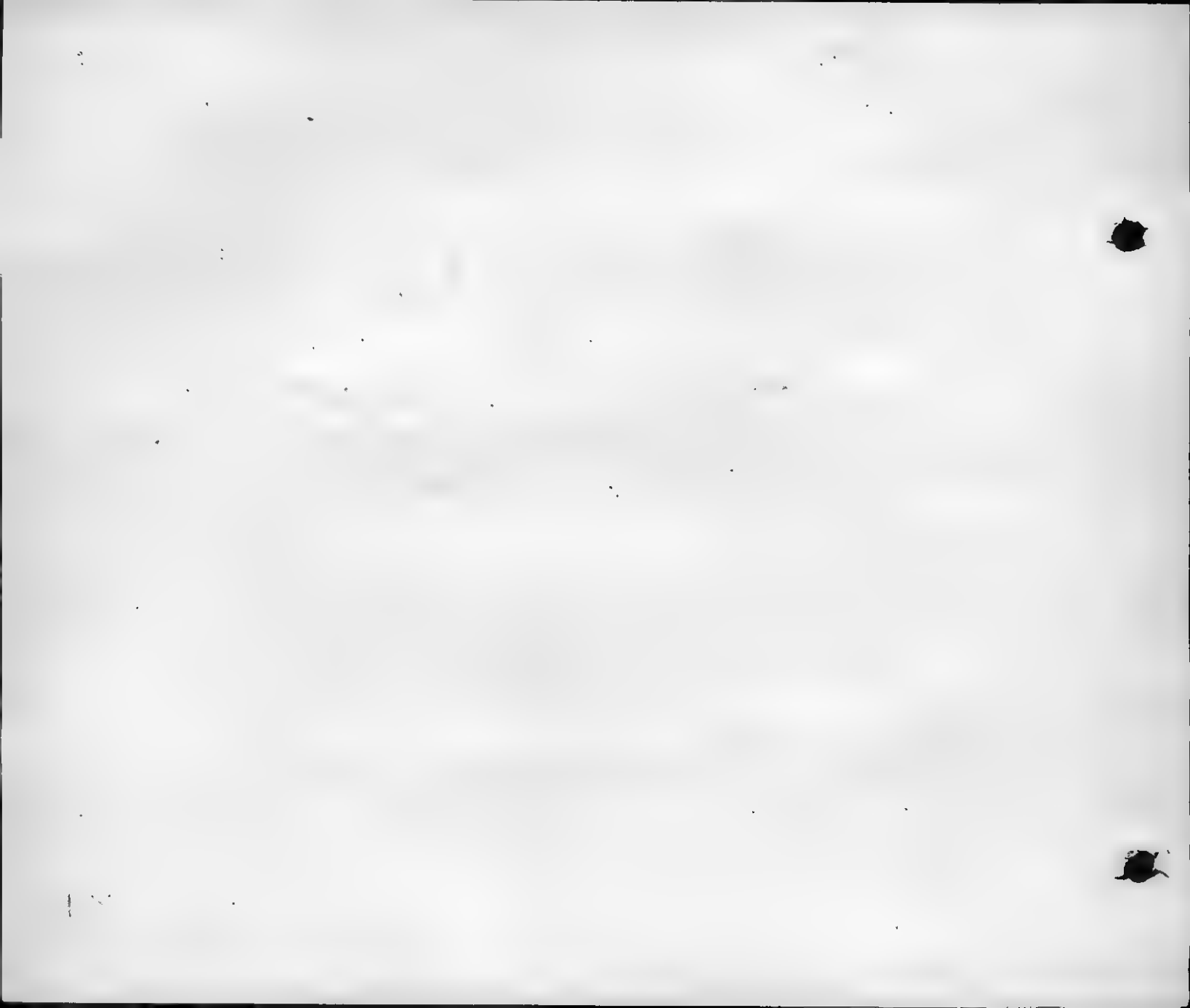
may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11889

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11874

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) Cordova		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RT. 1 Box 289 d. STREET ADDRESS 1 CORDOVA, Md.	
3. NAME OF DECEASED (Type or print) Ella First MARTHA Middle GROCE Last		4. DATE OF DEATH OCT. 2, 1961 Month Oct. Day 2 Year 1961	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 9, 1887 9. AGE (in years last birthday) 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Steven teat		14 MOTHER'S MAIDEN NAME Georgeanna teat	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 219-07-9858	
17. INFORMANT Mrs. Rosie Monroe Address Cordova, Md.			
18 CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above			
22a SIGNATURE Lorris M. Welch M.D.		22b DATE SIGNED 10-8-61	
22c PHYSICIAN'S NAME (Type) WELCH		22d ADDRESS Easton Md.	
23a BURIAL, CREMATION OR OTHER DISPOSAL (Specify) BURIAL	23b DATE THEREOF Oct. 7, 1961	23c NAME OF CEMETERY OR CREMATORY New Chapel Cem.	23d. LOCATION (City, town, or county) (State) Easton Rt. 1 Md.
24 FUNERAL DIRECTOR'S SIGNATURE Jamie Washell ADDRESS EASTON, Md.		25a REC'D BY REGISTRAR OCT 10 '61	25b REGISTRAR'S SIGNATURE Charles S. Kneass



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11890

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11875

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethlehem</i>	
c. LENGTH OF STAY IN 1b <i>2 d.</i>		d. STREET ADDRESS <i>352</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ruth</i> First <i>Lee</i> Middle <i>Harding</i> Last		4. DATE OF DEATH Month <i>10</i> Day <i>12</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 10, 1901</i>
9. AGE (In years lost birthday) <i>60</i> yrs		IF UNDER 1 YEAR Months <i>0</i> Days <i>3</i> Hours <i>2</i>	IF UNDER 24 HRS. Hours <i>2</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Thompson</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT <i>Harvey E. Harding, Bethlehem, Maryland</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO <i>Acute tracheo-bronchitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute tracheo-bronchitis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10 Oct 1961</i> to <i>12 Oct 1961</i> , that (I) (we) last saw the deceased alive on <i>12 Oct 1961</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above			
22a. SIGNATURE <i>Thorston Harrison</i>		22b. DATE <i>12 Oct 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>		22d. ADDRESS <i>Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 14, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Junior Order Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Preston, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Thompson</i>		25a. REC'D BY REGISTRAR <i>16 '61</i>	
ADDRESS <i>Federalsburg, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. House</i>	

(M)

(18)

7

1



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11891

CERTIFICATE OF DEATH

11876

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 5 hrs - 35 min	
d. NAME OF HOSPITAL (If not in hospita. give street address) OR INSTITUTION MEMORIAL Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle D Last HARPER SR		4. DATE OF DEATH Month 10 - Day 14 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 27, 1874
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER		12. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	
13. FATHER'S NAME JOHN C. HARPER		14. MOTHER'S MAIDEN NAME ROWENA AULD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT JAMES D. HARPER, JR.		Address BOZMAN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Fracture Hip - Left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 days (c) 5 days		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Calciphylactic Vasculitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Walking around house and fell - apparently hip broke before he fell	
20c. TIME OF INJURY Month, Day, Year Hour 10-9-61 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Boxman Talbot Md	
21. I certify that (I) (this hospital) attended the deceased from Oct 12, 1961 to 14 Oct 1961 that (I) last saw the deceased alive on 14 Oct 1961 and that death occurred at 1:15 PM , from the causes and on the date stated above			
22a. SIGNATURE R. Paul Wright		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF OCT 17, 1961	
23c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery		23d. LOCATION (City, town, or county) (State) Easton Md	
24. FUNERAL DIRECTOR'S SIGNATURE L. Hamilton Harrison		ADDRESS 4. Michael's md.	
25a. REC'D BY REGISTRAR DATE OCT 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
11892

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11877

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>				c. LENGTH OF STAY IN 1b <u>25 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>217 EASTON</u>			
f. STREET ADDRESS <u>1 704 Down At.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Angelina M.</u> Middle <u>Heinmuller</u> Last <u>Heinmuller</u>				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 23, 1886</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	IF UNDER 24 HRS Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRACTICAL N</u>		11. BIRTHPLACE (State or foreign country) <u>VEVEY, SWITZERLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JEAN MAGNE</u>				14. MOTHER'S MAIDEN NAME <u>CLARA LUTTI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>418-03-4968</u>		17. INFORMANT <u>ERNEST V. HEINMULLER</u> Address <u>EASTON, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the descending colon, metastatic to lymph nodes, brain and spleen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>colon, metastatic to lymph nodes, brain and spleen</u> (c) <u>nodes, brain and spleen</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased on _____, and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>E. C. H. Schmidt</u>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>200-1-19-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>					
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Oct. 21, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Easton, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. ...</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. ...</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11879

1. PLACE OF DEATH
a. COUNTY Talbot

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Near St Michaels

c. LENGTH OF STAY IN town

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Easton Memorial

3. NAME OF DECEASED
(Type or print) Guilford Edward Hoft Jr

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Paperhandler

10b. KIND OF BUSINESS OR INDUSTRY
Alco Engravers

11. BIRTHPLACE (State or foreign country)
Owings Mills Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME
Guilford Edward Hoft Sr.

14. MOTHER'S MAIDEN NAME
Bessie E. Sherman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service)
Yes Korean

16. SOCIAL SECURITY NO. 218-288442

17. INFORMANT
Patricia R. Hoben Hoft (Wife)

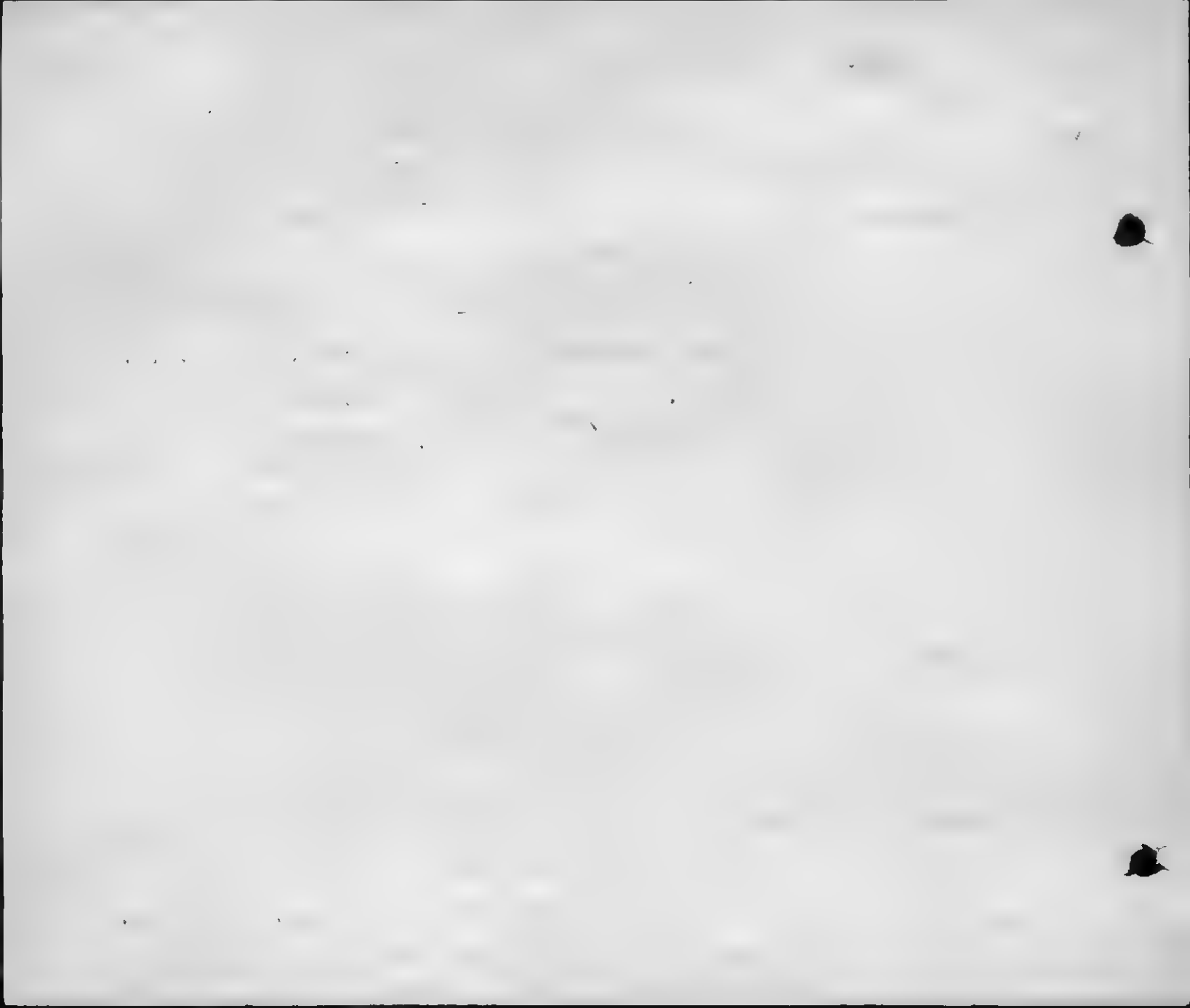
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
850X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH. ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Motor boat sank in Eastern Bay
20c. TIME OF INJURY Month, Day, Year
Hour e.m. Oct 15 1961
p.m.
20d. INJURY OCCURRED While ☒ Not While ☐ at work ☐ et work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Boat
20f. (City or town) (County) (State)
Talbot Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE E.C.H. Schmidt M.D.
EXAMINER'S NAME (Type) E.C.H. Schmidt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED 30 Oct 1961

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial
22b. DATE THEREOF
11-1-61
22c. NAME OF CEMETERY OR CREMATORY
St Thomas Cemetery
22d. LOCATION (City, town, or country) (State)
Garrison, Forest Md.

23. FUNERAL DIRECTOR
Frank H. Newell
ADDRESS
Pikesville, Md
24a. REC'D BY REGISTRAR
DATE NOV 1 '61
24b. REGISTRAR'S SIGNATURE
C. H. S. Hines



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11894

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1187

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Easton Memorial				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton R.D. # 1 d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Paul First P. Middle Knotts Jr. Last 4. DATE OF DEATH Month 10 Day 23 Year 19 61				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 2-28-1927 9. AGE (In years last birthday) 4 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Paul P. Knotts 14. MOTHER'S MAIDEN NAME Doris Henning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Paul P. Knotts Address Denton R.D. #1 Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningoceleemia, Sute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 Hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dawson P. George EXAMINER'S NAME (Type) Dawson O. George M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-24-61				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10-25-61 22c. NAME OF CEMETERY OR CREMATORY Greensboro 22d. LOCATION (City, town, or county) (State) Greensboro, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Boulaes ADDRESS Greensboro, Md. 24a. REC'D BY REGISTRAR DATE OCT 27 '61 24b. REGISTRAR'S SIGNATURE Thos B. H.							

MEDICAL CERTIFICATION

TO DENY: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11895

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11880

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>C 5x - None</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Koenenman</u> Last <u>Koenenman</u>		4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-1893</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Oscar Neff</u>		14. MOTHER'S MAIDEN NAME <u>Emma L. Hoffmann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>227-38-5856</u>	
17. INFORMANT <u>Lulford Swing Easton, Maryland</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO <u>left Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cerebrovascular</u> DUE TO <u>Disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. <u> </u> Day. <u> </u> Year <u> </u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1953</u> to <u>Oct 12 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 12 1961</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles H. Winnat</u> M.D.		22b. DATE SIGNED <u>10/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES H. WINNAT</u>		22d. ADDRESS <u>Ridgely, Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-16-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		23d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Boulaiz</u> ADDRESS <u>Greensboro Md</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	
25c. DATE <u>OCT 23 '61</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1186

11896

1. PLACE OF DEATH a. COUNTY <u>CAROTIVE Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>21 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Washington</u> Last <u>Langrell</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1888</u>	9. AGE (In years lost birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pet Milk Co. Machine Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ambrose Langrell</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Ovid Langrell Valley View, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Patcinoma of Prostate & Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Atherosclerosis; major Stumpel Spine</u> DUE TO (c) <u>Suprapubic Prostatectomy</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Greensboro, Maryland</u>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5.18.1961</u> to <u>10.11.1961</u> that (I) (we) lost saw the deceased alive on <u>10.10.1961</u> , and that death occurred at <u>10.11.1961</u> M, from the causes on and on the date stated above							
22a. SIGNATURE <u>John N. Robinson</u>				22b. ADDRESS <u>202 Dover St. Easton, Maryland</u>			
22c. PHYSICIAN'S NAME (Type) <u>John N. Robinson</u>				22d. ADDRESS <u>M.D. 202 Dover St. Easton, Maryland</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		23d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaw Greensboro, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

11897
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
Items 1-14-5-6-7-8-9-10a, 11-12-13-14 File G299 11/7/61 iwk

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN Tb 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Mem. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Robert LeCompte		4. DATE OF DEATH Month Day Year Oct 28 1961	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1886
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Neck Dist. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel E. LeCompte		14. MOTHER'S MAIDEN NAME Eliza Spedden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450-D Uremia, due to atherosclerotic suppurative DUE TO (b) (?) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive pulmonary emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1954 to 28 Oct 1961 , that (I) (we) last saw the deceased alive on Oct 28 19 61 , and that death occurred at 1230 PM, from the causes and on the date stated above.			
22a. SIGNATURE HURSTON HARRISON M.D.		22b. DATE SIGNED 31 Oct 61	
22c. PHYSICIAN'S NAME (Type) HURSTON HARRISON		22d. ADDRESS Carter, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Buried		23b. DATE THEREOF 10/30/61	
23c. NAME OF CEMETERY OR CREMATORY Camb. Cemetery		23d. LOCATION (City, town, or county) (State) Camb. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Sr. Camb. Md.		25. REC'D BY REGISTRAR DATE NOV 3 '61	
25b. REGISTRAR'S SIGNATURE Carter & Hanna			



CERTIFICATE OF DEATH

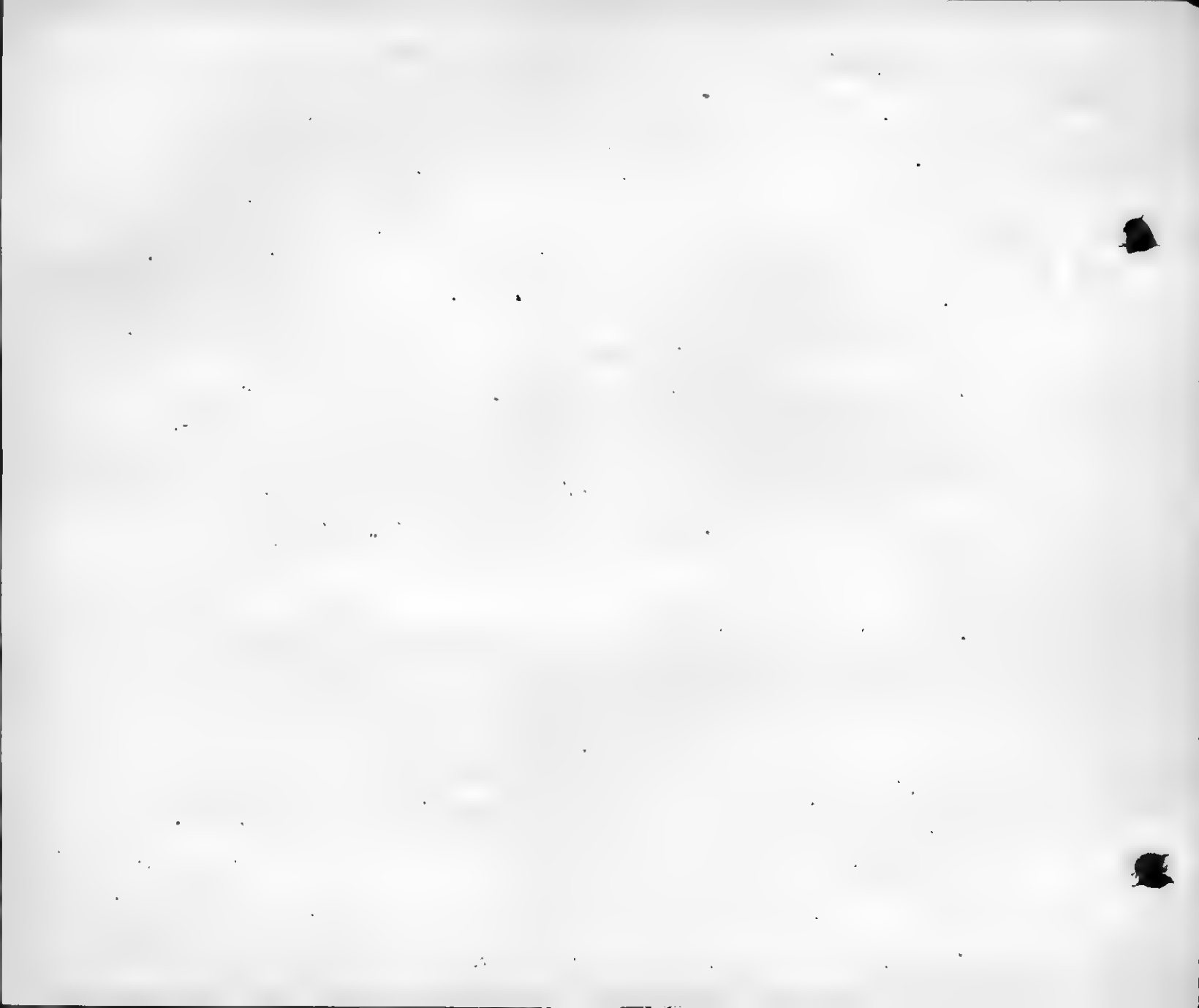
Reg. Dist. No. 1188.3

11898

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOZMAN</u>		c. LENGTH OF STAY IN TB <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ORMOND</u> Middle <u>J.</u> Last <u>LEDNUM</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 14, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>OLIVER M. LEDNUM</u>		14. MOTHER'S MAIDEN NAME <u>SARAH J. HADDAWAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Wilmer Lednum</u>		Address <u>Easton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>atherosclerotic cardiovascular d.</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic cardiac failure</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>4-12</u> , 19 <u>61</u> , to <u>10-29</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10-29</u> , 19 <u>61</u> , and that death occurred at <u>2:10</u> PM, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Guy M. Reeser Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michaels Md</u>	
PHYSICIAN'S NAME (Type) <u>Guy M Reeser Jr</u>		DATE SIGNED <u>10-30-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV 1, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BOZMAN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOZMAN Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. A. Hampton Harrison</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kline</u>	
ADDRESS <u>St Michaels Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	
DATE <u>NOV 3 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOPEFUL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11899

11884

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Trappe</u> LENGTH OF STAY in b <u>Entire Life</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>at Home</u>				d. STREET ADDRESS <u>Trappe</u>			
3. NAME OF DECEASED (Type or print) <u>Clarence Leonard</u>				4. DATE OF DEATH <u>Oct. 16</u> 19 <u>61</u>			
5. SEX <u>Male</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 11, 1878</u>	
9. AGE (In years last birthday) <u>83</u> yrs		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James M. Leonard</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Berry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-03-3847</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebromalacia</u> DUE TO (b) <u>Arterio sclerosis - generalized</u> DUE TO (c) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1957</u> to <u>10/16</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-16</u> , 19 <u>61</u> , and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William L. Winters</u>				22b. DATE SIGNED <u>10/18/61</u>		22c. PHYSICIAN'S NAME (Type) <u>William L. Winters</u>	
22d. ADDRESS <u>210 E. Dover St., Easton, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct 18, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	
23d. LOCATION (City, town or county) <u>Easton</u>				23e. (State) <u>Md.</u>		23f. REC'D BY REGISTRAR	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. Newnam & Son</u>				24b. ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	
DATE <u>OCT 19 '61</u>				25a. REGISTRAR'S SIGNATURE			



11900

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11885

1 PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 1 WK.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS Douglasville 17X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Nellie Middle T. Last MERRICK		4. DATE OF DEATH Month Oct Day 27 Year 1961	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 14 - 1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11 BIRTHPLACE (State or foreign country) Douglasville Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Charles Henry Roe Merrick		14 MOTHER'S MAIDEN NAME A. Katherine Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. None	
17. INFORMANT W R Wilson Jr. Address Douglasville Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A. H. D DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured femur, 5 days - Sensitivity		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19 10/22		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/22 1961, to 10/27 1961, that (I) (we) lost the deceased alive on Oct 27 1961, and that death occurred at 12 M from the causes and on the date stated above.			
22a. SIGNATURE Howard F. Kinnaman Jr. M.D.		22b. DATE SIGNED 11/1/61	
22c. PHYSICIAN'S NAME (Type) HOWARD F. KINNAMAN, M.D.		22d. ADDRESS Henrietta Avenue, Easton, Md	
23a. BYR AL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 31 - 1961	23c. NAME OF CEMETERY OR CREMATORY Seabrook	23d. LOCATION (City, town, or county) (State) Seabrook Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm. B. Borton ADDRESS 1 Borton Bn Crutcher Md		25a. REC'D BY REGISTRAR DATE NOV 3 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

11885



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11901

11886

11901

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Easton</u>	
c. LENGTH OF STAY IN 1b <u>30 days</u>		d. STREET ADDRESS <u>1 496 August Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kenneth Leroy Sard</u>		4. DATE OF DEATH Month Day Year <u>October 16 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1929</u>
9. AGE (In years last birthday) <u>32</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Sard</u>		14. MOTHER'S MAIDEN NAME <u>Emma Mills</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213 24 4694</u>	
17. INFORMANT <u>Mrs. Betty M. Sard, Easton, Maryland</u>		Address <u>406 August St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Embryonal Carcinoma of Right Testis</u> 178X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1960</u> to <u>10.16 1961</u> , that (I) (we) last saw the deceased alive on <u>10.16 1961</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>S. Krech, Jr.</u>		22b. DATE SIGNED <u>10.18.61</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. Krech, Jr.</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/18/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Trampton Carroll</u>		25a. REC'D BY REGISTRAR <u>W. Trampton Carroll</u> DATE <u>OCT 20 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

MEDICAL CERTIFICATION





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

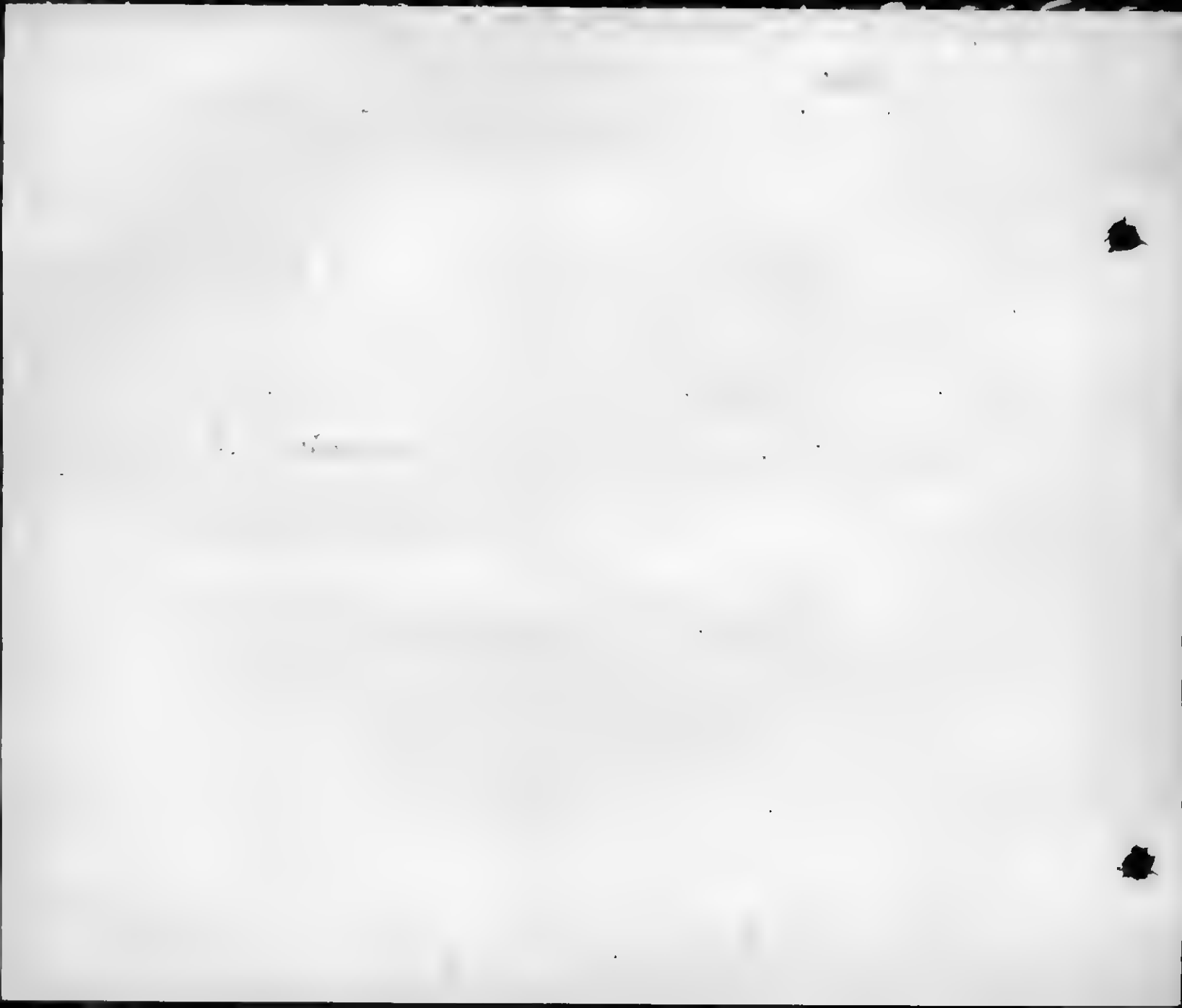
11903

11888

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton.		c. LENGTH OF STAY IN 1b 32 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Lena Sparks		4. DATE OF DEATH October 17 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 5, 1884
9. AGE (In years lost birthday) 77 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES WILLEY	
14. MOTHER'S MAIDEN NAME SARAH HARRISON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No	
16. SOCIAL SECURITY NO. —		17. INFORMANT MRS. JOHN STRICKBOTH, EASTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cachexia - severe DUE TO (b) melena - etiology? DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial failure, Hypertensive cardio vas. d.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1953 to 10-12 , 1961, that (I) (we) lost the deceased alive on 10-12 , 1961, and that death occurred at 3:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10-12-61	
22c. PHYSICIAN'S NAME (Type) Ray M. Reeser Jr.		22d. ADDRESS St. Michaels, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 20, 1961	23c. NAME OF CEMETERY OR CREMATORY Olint Cemetery	23d. LOCATION (City, town, or county) (State) St. Michaels, Md.
24. FUNERAL DIRECTOR'S SIGNATURE L. Hamilton Harrison, St. Michaels, Md.		25a. REC'D BY REGISTRAR OCT 23 '61	
25b. REGISTRAR'S SIGNATURE C. L. L. Kenna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

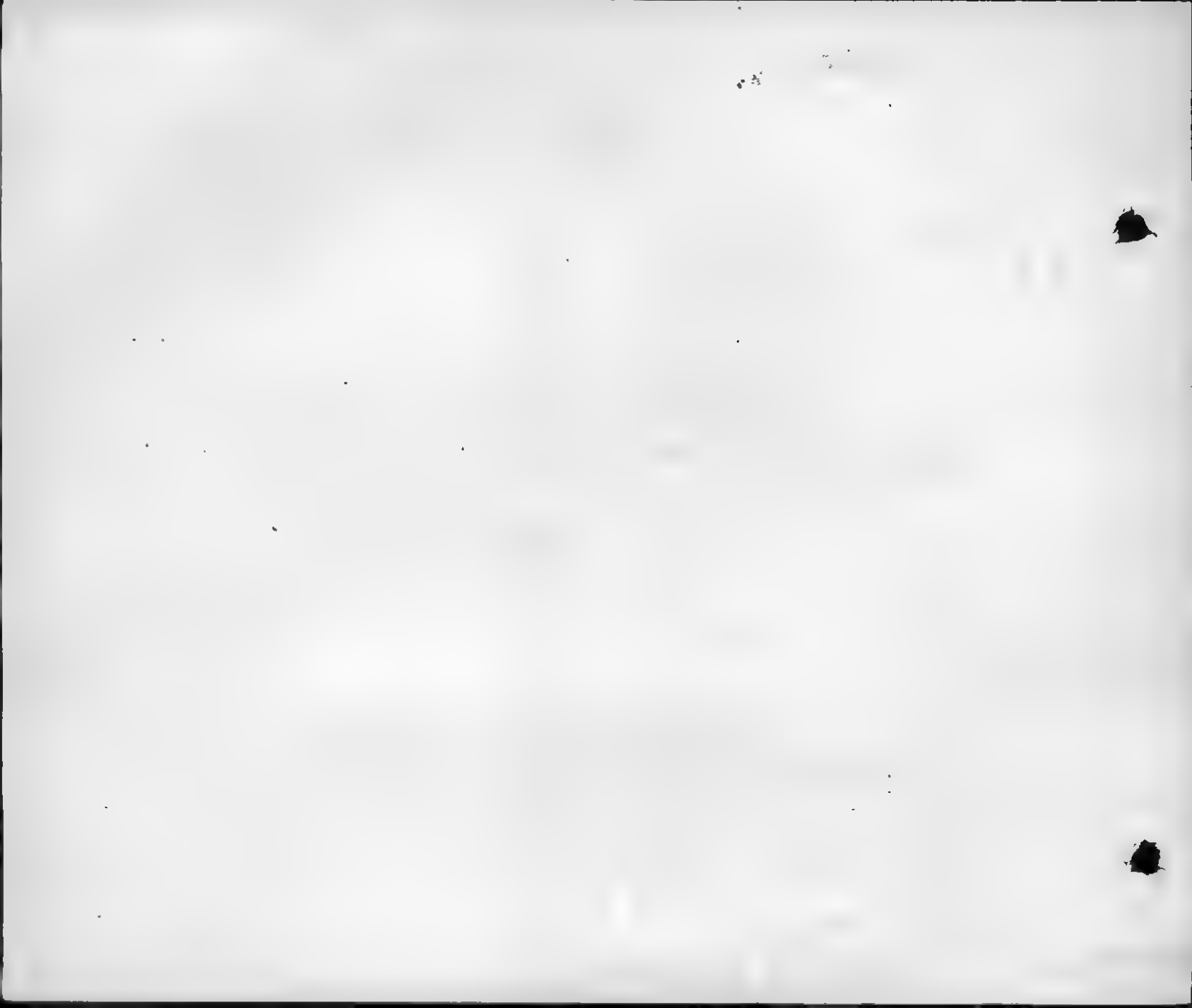
VR A15 (4)
ISM 9/59

11904

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1188.1

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		d. STREET ADDRESS <u>None</u> 05x - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>STACK</u> Last		4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1895</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	11. IF UNDER 24 HRS Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Master Ridgely</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John K. Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bechtel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lucy C. Lorgan</u>		Address <u>Allentown, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>576X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized peritonitis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12</u> to <u>19</u> that (I) (we) lost saw the deceased alive on <u>19</u> and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above		22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE <u>17 Oct 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-20-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		23d. LOCATION (City, town, or county) (State) <u>Near Greensboro, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais</u> ADDRESS <u>Greensboro, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 19 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

11905
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118511

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		d. STREET ADDRESS 11X-2	
3. NAME OF DECEASED (Type or print) Edith Thompson		4. DATE OF DEATH Oct. 11 1961	
5. SEX FEM	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11 - 1900
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SMITH		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT JAMES E. THOMPSON		Address QUEENTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Left ventricular failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic heart disease DUE TO (c) several years		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5-Oct-1961 to 11-Oct-1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11-Oct-1961 , and that death occurred at 7 AM , from the causes and on the date stated above.			
22a. SIGNATURE Dale R. Kellman M.D.		22b. DATE 11-Oct-1961	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/13/61	
23c. NAME OF CEMETERY OR CREMATORY KINGSLEY CHURCH		23d. LOCATION (City, town, or county) (State) CHESTER MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar J. Lane		25a. REC'D BY REGISTRAR DACT 16 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Hanna			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

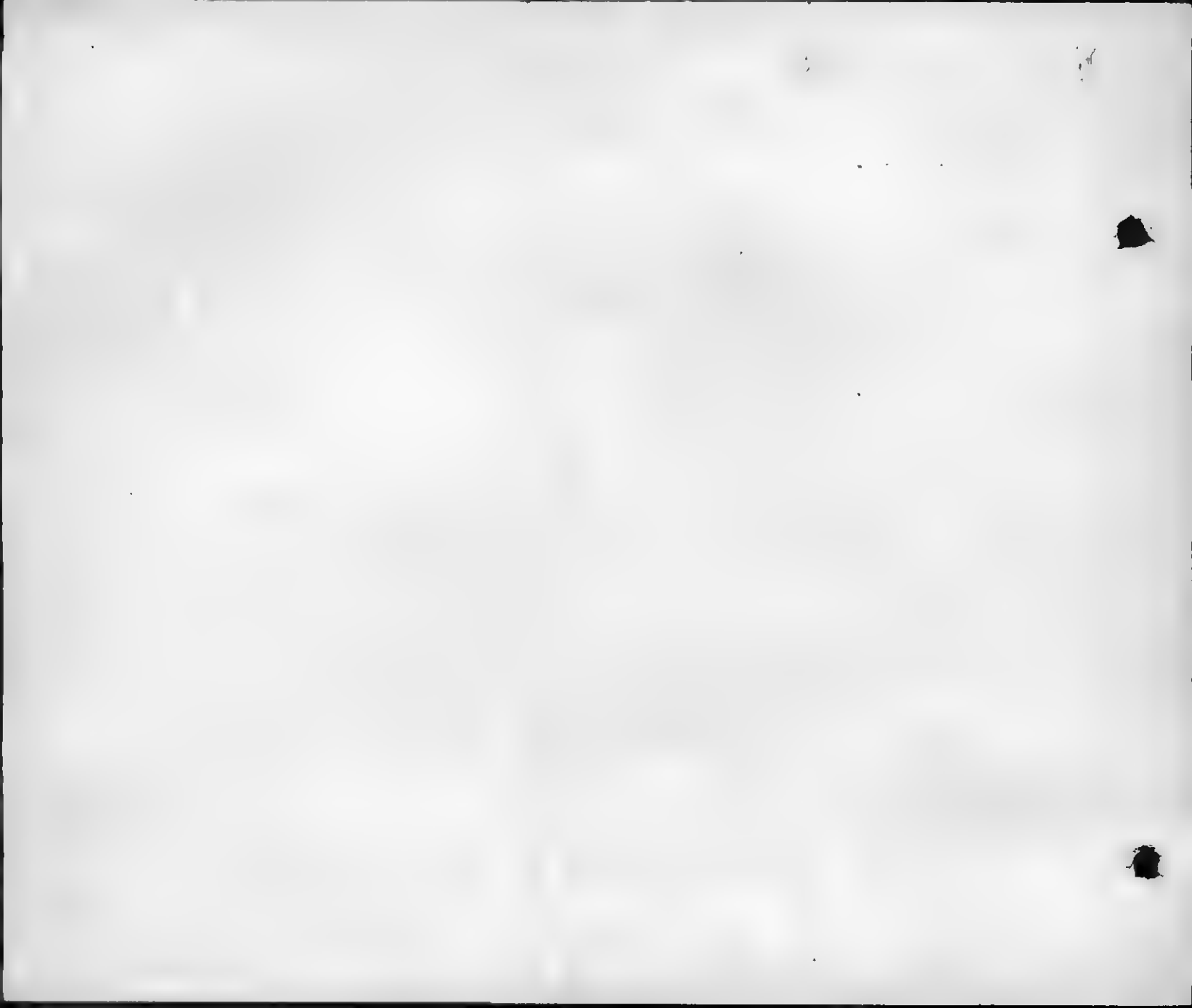
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11891

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 302 GOLDSDORO ST		d. STREET ADDRESS 302 GOLDSDORO	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRISON Middle TILGHMAN Last TILGHMAN		4. DATE OF DEATH Month OCT Day 11 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 6 - 1885
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months 1 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10b. KIND OF BUSINESS OR INDUSTRY LEGAL	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OSWALD TILGHMAN		14. MOTHER'S MAIDEN NAME BELLE HARRISON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES U.S.A.		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. HARRISON TILGHMAN, EASTON MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3:45 1960 to 11:00 1961 , that (I) (we) last saw the deceased alive on 31 Aug 1961 , and that death occurred at 5:00 AM , from the causes and on the date stated above			
22a. SIGNATURE Horstin Harrison		22b. DATE SIGNED 12/6/61	
22c. PHYSICIAN'S NAME (Type) HORSTIN HARRISON		22d. ADDRESS Carly, Maryland	
23a. BURIAL, CREMATION OR REMOVAL (Specify) 10/4/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY OXFORD		23d. LOCATION (City, town, or county) (State) OXFORD MD	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Clark		25a. REC'D BY REGISTRAR OCT 17 '61	
ADDRESS Easton Md		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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11892

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

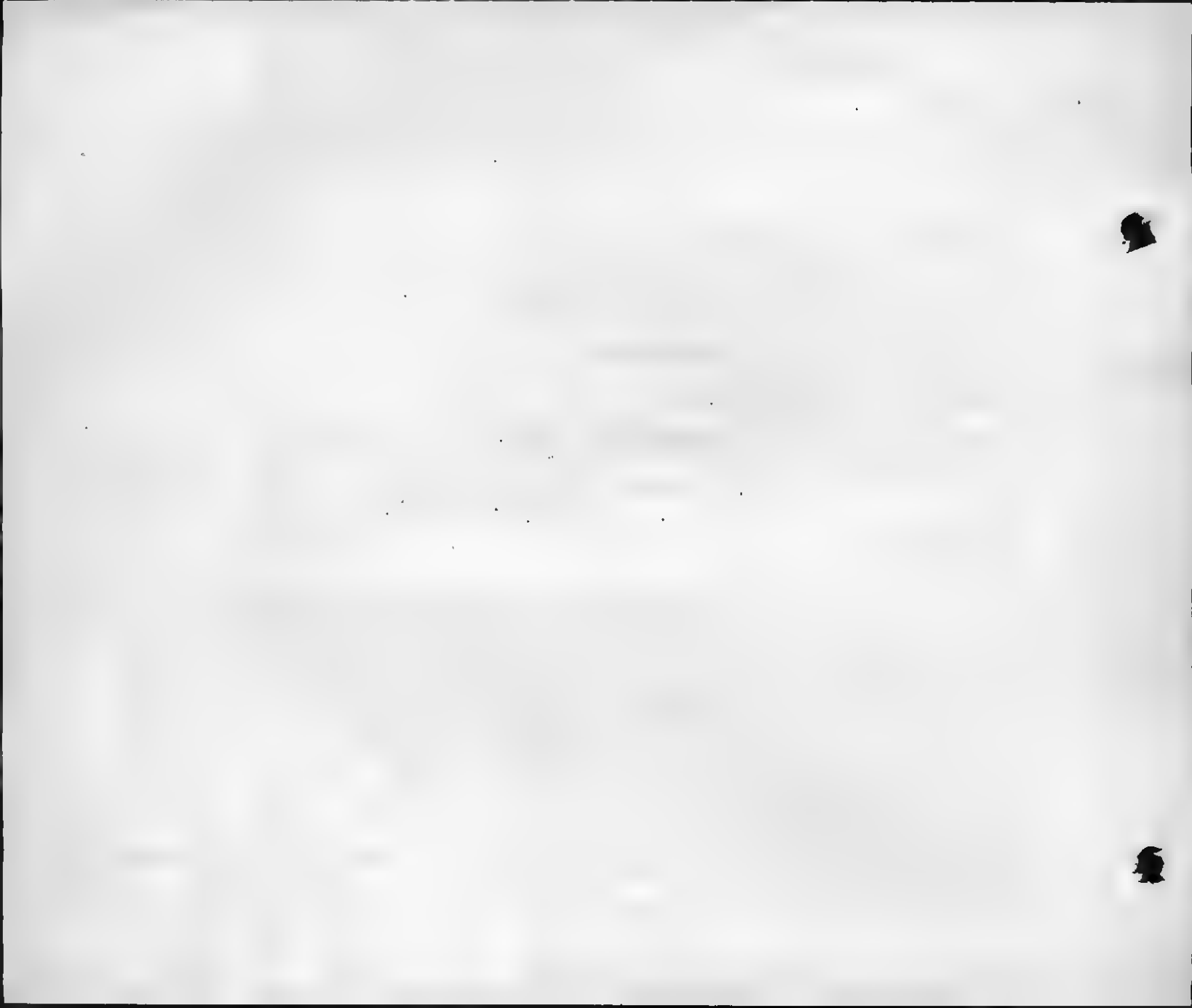
1. PLACE OF DEATH a. COUNTY <u>Albot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>13 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
f. STREET ADDRESS <u>17 x - 2</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Washington</u> Last <u>Washington</u>		4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1916</u>
9. AGE (In years last birthday) <u>44</u> yrs		10. IF UNDER 1 YEAR Months <u>44</u> Days <u>44</u> Hours <u>44</u> Min <u>44</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Griffin Washington</u>		14. MOTHER'S MAIDEN NAME <u>MARY Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>222-05-9826</u>	
17. INFORMANT <u>Paul Washington - Grasonville, Md.</u>		Address <u>Grasonville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line, in order of importance) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>4411-5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subarachnoid Hemorrhage</u> <u>Maligant Hypertension</u> (c) <u>2 years -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9-30-61</u> <u>9-30-61</u> <u>2 years -</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-30</u> 19 <u>61</u> to <u>10-12</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>10-12</u> 19 <u>61</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William L. Winters</u>		22b. DATE SIGNED <u>10/12/61</u>	
22c. PHYSICIAN'S NAME (Print) <u>WILLIAM L. WINTERS</u>		22d. ADDRESS <u>2106 DOVER EASTON MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 15, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bryans Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Grasonville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Schell, Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 17 '61</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>William L. Winters</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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Item 2 From birth certificate 11/1/61 1w

11893

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>112 Riverton Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Webb</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/61</u>
9. AGE (In years last birthday) yrs. <u>9</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u> Hours <u>12</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Rufus W. Webb</u>		14. MOTHER'S MAIDEN NAME <u>Betty Jane Penick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>11-71-10000</u>	
17. INFORMANT <u>Dr. Dale R. Kollman</u>		Address <u>16 N. 2nd St., Denton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immature development</u> DUE TO <u>761.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature labor</u> DUE TO (c) <u>Premature rupture of membranes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs. 8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/21/61</u> to <u>10/22/61</u> that (I) (we) last saw the deceased alive on <u>10/22/61</u> 19 <u>61</u> and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dale R. Kollman</u> M.D.		22b. DATE SIGNED <u>29-Oct-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dale R. Kollman, M.D.</u>		22d. ADDRESS <u>16 N. 2nd St., Denton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>10/30/61 Memorial Hospital</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Memorial Hospital, Denton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled out by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11909

11894

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HANNAH Behrens Wilke</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house work</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick August Behrens</u> RE		14. MOTHER'S MAIDEN NAME <u>Marie Garrels</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>215 36 2380</u>	
17. INFORMANT Address <u>Mr. Fritz Wilke, Box 207, Easton, RD, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal carcinoma</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adeno-Carcinoma of the ovary</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> to <u>OCT 15</u> , 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>SEP 14</u> , 19 <u>61</u> , and that death occurred at <u>6:50</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Kurt Lederer</u>		22b. DATE SIGNED <u>OCT 17 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>		22d. ADDRESS <u>QUEEN ANNE MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/17/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cordova, RD, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Frampton Carroll</u> ADDRESS <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 20 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

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STATE OF TEXAS

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